CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amendment)

907 KAR 10:825. Diagnosis-related group (DRG) inpatient hospital reimbursement.

RELATES TO: KRS 13B.140, 142.303, 205.510(16), 205.565, 205.637, 205.638, 205.639, 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.250-447.280, 42 U.S.C. 1395f(l), 1395ww(d)(5)(F), x(mm), 1396a, 1396b, 1396d, 1396r-4, Pub.L. 111-148

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 205.637(3), 205.640(1), 205.641(2), 216.380(12), 42 C.F.R. 447.200, 447.250, 447.252, 447.253, 447.271, 447.272, 42 U.S.C. 1396a, 1396r-4

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining the amount payable via a diagnosis-related group methodology by the Medicaid Program for acute care inpatient hospital services provided to a Medicaid recipient who is not enrolled with a managed care organization[~~a hospital inpatient service including provisions necessary to enhance~~

~~reimbursement pursuant to KRS 142.303 and 205.638~~].

Section 1. Definitions. (1) "2552-10 format" means the format used by the Centers for Medicare and Medicaid Services for a Medicare cost report period ending on or after April 1, 2011.

(2) "2552-96 format" means the format used by the Centers for Medicare and Medicaid Services for a Medicare cost report period ending prior to April 1, 2011.

(3) "Acute care hospital" is defined by KRS 205.639(1).

(4) "Aggregate target payments" means an outcome in which estimated aggregate payments in the universal rate year using trimmed base year claims data do not exceed trimmed base year claims data aggregated reported payments adjusted by the trending factor.

(5)[~~(2) "Adjustment factor" means the factor by which non-neonatal care relative weights shall be reduced to offset the expenditure pool adjustment necessary to enhance neonatal care relative weights.~~

~~(3)~~] "Appalachian Regional Hospital System" means a private, not-for-profit hospital chain operating in a Kentucky county that receives coal severance tax proceeds.

(6) "APR-DRG" means the clinically similar grouping of services that:

(a) Can be expected to consume similar amounts of hospital resources assigned by 3M's All-Patient Refined Diagnosis Related Group software; and

(b) Includes the:

1. Diagnosis related group;

2. Severity of illness assignment; and

3. Risk of mortality subclass.

(7) "APR-DRG average length of stay" means the arithmetic mean length of stay for each APR-DRG, calculated by multiplying the 3M national average length for each APR-DRG by a day's adjustment factor.

(8) "APR-DRG base payment" means the base payment for claims paid under the DRG methodology.

(9) "APR-DRG base rate" means the per discharge statewide APR-DRG rate for an acute care hospital that is multiplied by the relative weight and applicable policy adjuster to calculate the DRG base payment.

(10) "APR-DRG relative weight" means the factor that is:

(a) Assigned to each APR-DRG that represents the average resources required for an APR-DRG classification paid under the DRG methodology relative to the average resources required for all DRG discharges in the state paid under the DRG methodology for the same time period; and

(b) Calculated by dividing the 3M APR-DRG national weights by a case mix scaling factor.

(11)[~~(4) "Base rate" means the per discharge hospital-specific DRG rate for an acute care hospital that is multiplied by the relative weight to calculate the DRG base payment.~~

~~(5)~~] "Base year" means:

(a) For establishing the initial APR-DRG base rates effective April 1, 2014,[~~the~~] state fiscal year 2010; and

(b) In subsequent years for the purpose of rebasing rates, the state fiscal year that includes the most recently fully adjudicated state fiscal year of claims data available at

the time that the rate calculations are performed[~~period used to establish DRG rates~~].

(12) "Case mix scaling factor" means the multiplier necessary that results in the statewide average case mix index equaling 1.0 using trimmed base year claims data.

(13)[~~(6) "Base year Medicare rate components" means Medicare inpatient prospective payment system rate components in effect on October 1 during the base year as listed in the CMS IPPS Price Program.~~

~~(7) "Budget neutrality" means that reimbursements resulting from rates paid to providers under a per discharge methodology do not exceed payments in the base year adjusted for inflation based on the CMS Input Price Index, which is the wage index published by CMS in the Federal Register.~~

~~(8) "Budget neutrality factor" means a factor that is applied to a DRG base rate or the direct graduate medical educational payment so that budget neutrality is achieved.~~

~~(9) "Capital cost" means capital related expenses including insurance, taxes, interest and depreciation related to plant and equipment.~~

~~(10)~~] "CMS" means the Centers for Medicare and Medicaid Services.

(14)[~~(11)~~] "CMS IPPS Pricer Program" means the software program published on the CMS website of http://www.cms.hhs.gov which shows the Medicare rate components and payment rates under the Medicare inpatient prospective payment system for a discharge within a given federal fiscal year.

(15) "Coding and documentation improvement adjustment" means an adjustment to the APR-DRG relative weights to account for changes in case mix due to improvements in medical record documentation and improvements in claim coding.

(16) "Corridor adjustment factors" means the provider-specific adjustment factors

applied to the total hospital-specific per discharge payment that result in estimated provider pay-to-cost ratios using base year claims data being within the pay-to-cost corridor.

(17)[~~(12)~~] "Cost center specific cost-to-charge ratio" means a ratio of a hospital's cost center specific total hospital costs to its cost center specific total charges extracted from the Medicare cost report that best matches[~~corresponding to the hospital full fiscal year falling within~~] the base year claims data[~~date~~] period.

(18)[~~(13)~~] "Cost outlier" means a claim for which estimated cost exceeds the outlier threshold.

(19)[~~(14)~~] "Critical access hospital" or "CAH" means a hospital:

(a) Meeting the licensure requirements established in 906 KAR 1:110; and

(b) Designated as a critical access hospital by the department.

(20)[~~(15)~~] "Department" means the Department for Medicaid Services or its designated agent.

(21)[~~(16)~~] "Diagnosis codes[~~code~~]" means the codes[~~a code~~]:

(a) Used by the department's grouper software[~~Maintained by the Centers for Medicare and Medicaid Services (CMS)~~] to group and identify a disease, disorder, symptom, or medical sign; and

(b) Used to measure morbidity and mortality.

(22)[~~(17) "Diagnostic categories" means the diagnostic classifications containing one or more DRGs used by Medicare programs, assigned in the base year with modifications established in Section 2(15) of this administrative regulation.~~

~~(18)~~] "Diagnostic related group" or "DRG" means a clinically-similar grouping of ser-

vices that can be expected to consume similar amounts of hospital resources.

(23)[~~(19)~~] "Distinct part unit" means a separate unit within an acute care hospital that meets the qualifications established in 42 C.F.R. 412.25 and is designated as a distinct part unit by the department.

(24) "Enrollee day" means a day of an inpatient hospital stay of a Medicaid recipient who is enrolled with a managed care organization.

(25)[~~(20) "DRG average length of stay" means the Kentucky arithmetic mean length of stay for each DRG, calculated by dividing the sum of patient days in the base year claims data for each DRG by the number of discharges for each DRG.~~

~~(21) "DRG base payment" means the base payment for claims paid under the DRG methodology.~~

~~(22) "Enhanced neonatal care relative weight" means a neonatal care relative weight increased, with a corresponding reduction to non-neonatal care relative weights, to facilitate reimbursing neonatal care at 100 percent of Medicaid allowable costs in aggregate by category.~~

~~(23)~~] "Federal financial participation" is defined by 42 C.F.R. 400.203.

(26)[~~(24)~~] "Fixed loss cost threshold" means[~~the amount, equal to~~] $29,000.

(27)[~~, which is combined with the full DRG payment or transfer payment for each DRG to determine the outlier threshold.~~

~~(25) "Geometric mean" means the measure of central tendency for a set of values expressed as the nth (number of values in the set) root of their product.~~

~~(26)~~] "Government entity" means an entity that qualifies as a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).

[~~(27) "High intensity level II neonatal center" means an in-state hospital with a level II neonatal center which:~~

~~(a) Is licensed for a minimum of twenty-four (24) neonatal level II beds;~~

~~(b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;~~

~~(c) Has a gestational age lower limit of twenty-seven (27) weeks; and~~

~~(d) Has a full-time perinatologist on staff.~~]

(28)[~~"High volume per diem payment" means a per diem add-on payment made to hospitals meeting selected Medicaid utilization criteria established in Section 2(12) of this administrative regulation.~~

~~(29)~~] "Hospital-acquired condition" means a condition:

(a)1. Associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D); and

2. Not present upon the recipient's admission to the hospital; or

(b) Which is recognized by the APR-DRG grouper[~~Centers for Medicare and Medicaid Services~~] as a hospital-acquired condition.

(29)[~~(30) "Indexing factor" means the percentage that the cost of providing a service is expected to increase during the universal rate year.~~

~~(31)~~] "Inflation factor" means the percentage that the cost of providing a service has increased, or is expected to increase, for a specific period of time based on changes in the CMS IPPS hospital input price index.

(30)[~~(32)~~] "Intrahospital transfer" means a transfer within the same acute care hospital resulting in a discharge from and a new admission to a licensed and certified acute care bed, psychiatric distinct part unit, or rehabilitation distinct part unit.

(31)[~~(33) "Level I neonatal care" or "Level 1 DRG" means care provided to newborn infants of a more intensive nature than the usual nursing care provided in newborn care units, on the basis of physicians' orders and approved nursing care plans, which are assigned to DRGs 385-390.~~

~~(34) "Level II neonatal center" means a facility with a licensed level II bed which provides specialty care (DRGs 675-680) for infants which includes monitoring for apnea spells, incubator or other assistance to maintain the infant's body temperature, and feeding assistance.~~

~~(35) "Level III neonatal center" means a facility with a licensed level III bed which provides specialty care (DRGs 685-690) of infants which includes ventilator or other respiratory assistance for infants who cannot breathe adequately on their own, special intravenous catheter to monitor and assist blood pressure and heart function, observation and monitoring of conditions that are unstable or may change suddenly, and post-operative care.~~

~~(36)~~] "Long-term acute care hospital" means a long term care hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(32) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(33) "Medicaid fee-for-service claim" means a claim related to care provided to a Medicaid recipient who is not enrolled with a managed care organization.

(34) "Medicaid fee-for-service covered day" means an inpatient hospital day associated with a Medicaid recipient who is not enrolled with a managed care organization.

(35)[~~(37) "Low intensity level III neonatal center" means a facility with one (1), two (2), or three (3) licensed level III neonatal beds.~~

~~(38)~~] "Medicaid shortfall" means the difference between a provider's allowable cost of providing services to Medicaid recipients and the amount received in accordance with the payment provisions established in Section 2 of this administrative regulation.

(36)[~~(39)~~] "Medical education costs" means direct and allowable costs that are:

(a) Associated with an approved intern and resident program; and

(b) Subject to limits established by Medicare.

(37) "MDC" means the major diagnostic categories associated with each APR-DRG classification.

(38)[~~(40)~~] "Medically necessary" or "medical necessity" means that a covered benefit shall be provided in accordance with 907 KAR 3:130.

(39)[~~(41)~~] "Never event" means:

(a) A procedure, service, or hospitalization not reimbursable by Medicare pursuant to CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101; or

(b) A hospital-acquired condition.

(40)[~~(42)~~] "Outlier threshold" means the sum of the APR-DRG base payment or transfer payment and the fixed loss cost threshold.

(41)[~~(43)~~] "Pediatric teaching hospital" is defined in KRS 205.565(1).

(42)[~~(44)~~] "Per diem rate" means the per diem rate paid by the department for:

(a) Inpatient care in an in-state psychiatric or rehabilitation hospital;

(b)[~~,~~] Inpatient care in a long-term acute care hospital;

(c)[,] Inpatient care in a critical access hospital,

(d)[~~or~~] Psychiatric, substance use disorder, or rehabilitation services in an in-state acute care hospital which has a distinct part unit; or

(e) A psychiatric or rehabilitation service in an in-state acute care hospital with an assigned psychiatric, substance use disorder, or rehabilitation APR-DRG.

(43) "Policy adjusters" means the factor applied to increase payments for APR-DRG base payments for normal newborn, neonatal, and maternity services.

(44)[~~(45)~~] "Psychiatric hospital" means a hospital which meets the licensure requirements as established in 902 KAR 20:180.

(45)[~~(46)~~] "Quality improvement organization" or "QIO" means an organization that complies with 42 C.F.R. 475.101.

(46)[~~(47)~~] "Rebase" means to redetermine APR-DRG base rates, DRG relative weights, policy adjusters, corridor adjustments, per diem rates, and other applicable components of the payment methodology using more recent claims data and cost report data.

(47)[~~(48)~~] "Rehabilitation hospital" means a hospital meeting the licensure requirements as established in 902 KAR 20:240.

(48)[~~(49) "Relative weight" means the factor assigned to each Medicare DRG classification that represents the average resources required for a Medicare DRG classification paid under the DRG methodology relative to the average resources required for all DRG discharges in the state paid under the DRG methodology for the same time period.~~

~~(50)~~] "Resident" means an individual living in Kentucky who is not receiving public

assistance in another state.

(49)[~~(51)~~] "Rural hospital" means a hospital located in a rural area pursuant to 42 C.F.R. 412.64(b)(1)(ii)(C).

(50)[~~(52)~~] "State university teaching hospital" means:

(a) A hospital that is owned or operated by a Kentucky state-supported university with a medical school; or

(b) A hospital:

1. In which three (3) or more departments or major divisions of the University of Kentucky or University of Louisville medical school are physically located and which are used as the primary (greater than fifty (50) percent) medical teaching facility for the medical students at the University of Kentucky or the University of Louisville; and

2. That does not possess only a residency program or rotation agreement.

(51) "Statewide weighted average pay-to-cost ratio" means statewide total estimated payments in the universal rate year using trimmed base year claims divided by statewide total estimated costs in the universal rate year using trimmed base year claims data.

(52)[~~(53)~~] "Transfer payment" means a payment made for a recipient who is transferred to or from another hospital for a service reimbursed on a prospective discharge basis.

(53)[~~(54)~~] "Trending factor" means the cumulative percentage increase in the DRG or APR-DRG base rates that has occurred since the base year claims data period to[~~inflation factor as applied to that period of time between the midpoint of the base year and the midpoint of~~] the universal rate year.

(54) "Trimmed base year claims data" means base year claims data excluding:

(a) Claims data for a discharge reimbursed on a per diem basis including:

1. A psychiatric claim including:

a. An acute care hospital claim with a psychiatric or substance use disorder APR-DRG;

b. A psychiatric distinct part unit claim;

c. A psychiatric hospital claim including one (1) related to substance use disorder treatment; or

d. A claim not referenced in clause c of this subparagraph that is related to substance use disorder treatment;

2. A rehabilitation claim including:

a. An acute care hospital claim with a rehabilitation APR-DRG;

b. A rehabilitation distinct part unit claim; or

c. A rehabilitation hospital claim;

3. A critical access hospital claim; or

4. A long term acute care hospital claim;

(b) A claim for a patient discharged from an out-of-state hospital;

(c) A claim with total charges equal to zero (0);

(d) A managed care organization claim; or

(e) A claim for a hospital-based skilled nursing facility or long-term care unit.

(55) "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School.

(56) "Universal rate year" means the twelve (12) month period under the prospective payment system, beginning July of each year, for which a payment rate is established for a hospital regardless of the hospital's fiscal year end.

(57) "Urban hospital" means a hospital located in an urban area pursuant to 42 C.F.R. 412.64(b)(1)(ii).

(58) "Urban trauma center hospital" means an acute care hospital that:

(a) Is designated as a Level I Trauma Center by the American College of Surgeons;

(b) Has a Medicaid utilization rate greater than twenty-five (25) percent; and

(c) Has at least fifty (50) percent of its Medicaid population as residents of the county in which the hospital is located.

Section 2. Payment for an Inpatient Acute Care Service in an In-state Acute Care Hospital. (1) An in-state acute care hospital shall be paid for an inpatient acute care service, except for a service not covered pursuant to 907 KAR 10:012, on a fully-prospective per discharge basis.

(2) For an inpatient acute care service, except for a service not covered pursuant to 907 KAR 10:012, in an in-state acute care hospital, the total hospital-specific per dis-charge payment shall be the APR-DRG[~~sum of:~~

~~(a) A DRG~~] base payment and, if applicable, a cost outlier[~~;~~

~~(b) If applicable, a high volume per diem payment; and~~

~~(c) If applicable, a cost outlier~~] payment amount multiplied by the provider-specific corridor adjustment.

(3)(a) In assigning an APR-[~~a~~]DRG for a claim, the department shall exclude from the APR-DRG consideration any secondary diagnosis code associated with a never

event.

(b)1. For rates effective April 1, 2014, the department shall assign an APR-[~~A~~]DRG[~~assignment~~] for payment purposes[~~shall be~~] based on the 3M APR-DRG[~~Medicare~~] grouper version thirty (30).

2. Beginning on October 1, 2014, the department shall update the APR-DRG grouper version using the most current APR-DRG grouper version available and update it each subsequent October 1 using the most current APR-DRG grouper version available.

3. If, on a given October 1, a new version of the APR-DRG grouper is not available, the department shall not update the APR-DRG grouper version until a new version becomes available[~~twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006.~~

~~(c) The department shall assign to the base year claims data, DRG classifications from Medicare grouper version twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006~~].

(4) An APR-[~~A~~]DRG base payment shall be calculated for a discharge by multiplying the statewide APR-DRG[~~hospital specific~~] base rate by the APR-DRG relative weight and the applicable policy adjuster.

(5)(a) The department shall determine a single statewide APR-DRG base rate in a way that results in the estimated aggregated payments in the universal rate year using trimmed base year claims data not exceeding aggregated reported payments in the trimmed base year claims data adjusted by the trending factor.

(b)1. The department shall assign to the base year claims data, APR-DRG classifications from the same APR-DRG grouper version that shall be used for payment during

the universal rate year.

2. For rates effective April 1, 2014, the base year claims data means claims data from state fiscal year 2010.

3. In rebasing, the department shall use the state fiscal year that includes the most recent fully adjudicated state fiscal year Medicaid fee-for-service claims data available at the time of the rate calculation.

(c) The department shall determine a statewide APR-DRG base rate using the trimmed base year claims data.

(d) In estimating payments in the universal rate year for the purpose of determining the statewide APR-DRG base rate, the department shall:

1. Include policy adjusters referenced in subsection (6) of this section; and

2. Exclude corridor adjustments referenced in subsection (10) of this section.

(6)(a) The department shall apply a single policy adjuster to an APR-DRG base payment for the following:

1. A claim with a newborn APR-DRG assignment in MDC 15; and

2. A claim with a maternity related APR-DRG assignment in MDC 14.

(b)1. The department shall determine the policy adjuster factor using trimmed base year claims data for newborn and maternity APR-DRGs in a manner that results in the following outcomes when applying the policy adjuster factor to APR-DRG base payments:

a. Estimated aggregated payments in the universal rate year excluding corridor adjustments for these claims exceed aggregated trimmed base year claims data reported payments, adjusted by the trending factor, by the smallest margin possible; and

b. The policy adjuster factor is incrementally rounded upwards to the nearest five (5)-hundredths.

2. An example of the provisions described in subparagraph 1. of this paragraph is if a policy adjuster factor of 1.418 results in estimated aggregated payments without corridor adjustments using trimmed base year claims data with newborn and maternity APR-DRGs that exceed aggregated base year claim reported payments adjusted by the trending factor by the smallest margin possible, the policy adjuster factor shall be rounded upwards to 1.45.

(c) In estimating payments in the universal rate year for the purpose of determining the APR-DRG base rate, the department shall:

1. Include policy adjusters referenced in subsection (6) of this section; and

2. Exclude corridor adjustments referenced in subsection (10) of this section.

(7)(a)[~~by calculating a case mix, outlier payment and budget neutrality adjusted cost per discharge for each in-state acute care hospital as described in subsections (5)(b) through (10) of this section of this administrative regulation.~~

~~(b) A hospital specific cost per discharge used to calculate a base rate shall be based on base year inpatient paid claims data.~~

~~(c) A hospital specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.~~

~~(6)(a)~~] The department shall calculate a cost to charge ratio for the seventeen (17)[~~fifteen (15)~~] Medicaid and Medicare cost centers displayed in paragraph (b) of this subsection using Medicare cost reporting periods as established in Section 1(17) of this administrative regulation.

(b) If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is not within[~~above or below~~] three (3) standard deviations from the mean of the set[~~a log distribution~~] of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk		
Kentucky Medicaid Cost Center	Kentucky Medicaid Cost Center Description	Medicare Cost Report Standard Cost Center (2552-96 format)
1	Routine Days	25
2	Intensive Days (non-neonatal)	26, 27, 28, 29, 30
3	Drugs	48, 56
4	Supplies or equipment	55, 66, 67
5	Therapy services excluding inhalation therapy	50, 51, 52
6	Inhalation therapy	49
7	Operating room	37, 38
8	Labor and delivery	39
9	Anesthesia	40
10	Cardiology	53, 54
11	Laboratory	44, 45
12	Radiology	41, 42

13	Other services	43, 46, 47, 57, 58, 59, 60, 61, 62, 63, 63.5, 64, 65, 68
14	Nursery	33
15	Neonatal intensive days	Various[~~30~~]
16	Psychiatric	Various
17	Rehabilitation	Various

Table 2. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk		
Kentucky Medicaid Cost Center	Kentucky Medicaid Cost Center Description	Medicare Cost Report Standard Cost Center (2552-10 format)
1	Routine Days	30
2	Intensive Days (non-neonatal)	31, 32, 33, 34, 35
3	Drugs	64, 73
4	Supplies or equipment	71, 72, 96, 97
5	Therapy services excluding inhalation therapy	66, 67, 68
6	Inhalation therapy	65
7	Operating room	50, 51
8	Labor and delivery	52
9	Anesthesia	53

10	Cardiology	59, 69, 70
11	Laboratory	60, 61
12	Radiology	54, 55, 57
13	Other services	56, 58, 62, 63, 74, 75, 76, 88, 90, 91, 92, 93, 94, 95, 98
14	Nursery	43
15	Neonatal intensive days	Various
16	Psychiatric	Various
17	Rehabilitation	Various

(8)[~~(7)~~](a) For a hospital with an intern or resident reported on its Medicare cost report, the department shall calculate allocated overhead by computing the difference between the costs of interns and residents before and after the allocation of overhead costs.

(b) The ratio of overhead costs for interns and residents to total facility costs shall be multiplied by the costs in each cost center prior to computing the cost center cost-to-charge ratio.

[~~(8) For an in-state acute care hospital, the department shall compile the number of patient discharges, patient days and total charges from the base year claims data. The department shall exclude from the rate calculation:~~

~~(a) Claims paid under a managed care program;~~

~~(b) Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;~~

~~(c) Transplant claims; and~~

~~(d) Revenue codes not covered by the Medicaid Program.~~]

(9)(a) The department shall calculate the cost of[~~a~~] base year claims data used in the determination of APR-DRG base rates[~~claim~~] by multiplying the charges from each in-patient hospital-related[~~accepted~~] revenue code by the corresponding cost center specific cost-to-charge ratio.

(b) The department shall inflate the cost of base year claims data to the universal rate year using an inflation factor based on changes in CMS IPPS hospital input price index levels[~~base cost center specific cost-to-charge ratios on data extracted from the most recently, as of June 1, finalized cost report~~].

(c)1.[~~Only an~~] Inpatient revenue codes for services reimbursed[~~code recognized~~] by the department under the APR-DRG methodology shall be included in the calculation of estimated costs.

2. Any inpatient revenue code for a service not reimbursed by the department under the APR-DRG methodology shall not be included in the calculation of estimated costs.

(10)(a) The department shall apply a provider-specific corridor adjustment to the sum of the APR-DRG base payment and the applicable outlier payment.

(b)1. To determine corridor adjustment factors, the department shall establish a pay-to-cost ratio corridor based on the statewide weighted average pay-to-cost ratio using the same trimmed base year claims data used in the statewide APR-DRG base rate calculation.

2. The pay-to-cost ratio corridor ceiling shall be five (5) percent above the statewide weighted average pay-to-cost ratio subject to the increase or decrease in accordance

with paragraph (c)4 of this subsection.

3. The pay-to-cost ratio corridor floor shall be five (5) percent below the statewide average weighted average pay-to-cost ratio.

(c) The department shall determine corridor adjustment factors based on each hospital's estimated pay-to-cost ratio before corridor adjustments relative to the pay-to-cost ratio corridor using the same trimmed base year claims data used in the statewide APR-DRG base rate calculation.

1. For a provider with a pay-to-cost ratio that is below the pay-to-cost ratio corridor floor, the provider-specific corridor adjustment factor shall be set to increase payments in a way that results in the pay-to-cost ratio equaling the corridor floor.

2. For a provider with a pay-to-cost ratio that is within the pay-to-cost ratio corridor, the provider-specific corridor adjustment factor shall be set to 1.0.

3. For a provider with a pay-to-cost ratio above the pay-to-cost ratio corridor ceiling, the provider-specific corridor adjustment factor shall be set to reduce payments in a way that results in the pay-to-cost ratio equaling the corridor ceiling.

4. The pay-to-cost ratio ceiling shall be increased or decreased until estimated aggregated payments with corridor adjusters in the universal rate year do not exceed trimmed base year claims data aggregated reported payments adjusted by the trending factor.

(d) Corridor adjustment factors shall:

1. Be determined on a prospective basis; and

2. Not be updated until the system is rebased.

(11)(a)[~~(10) Using the base year Medicaid claims referenced in subsection (8) of this~~

~~section, the department shall compute a hospital specific cost per discharge by dividing a hospital's Medicaid costs by its number of Medicaid discharges.~~

~~(11) The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's specific Medicaid allowable cost per discharge by the hospital's case mix, expected outlier payments and budget neutrality.~~

~~(a)1. A hospital's case mix adjusted cost per discharge shall be calculated by dividing the hospital's cost per discharge by its case mix index; and~~

~~2. The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in sub-section (8) of this section.~~

~~(b)1. A hospital's case mix adjusted cost per discharge shall be multiplied by an initial budget neutrality factor.~~

~~2. The initial budget neutrality factor for a rate shall be 0.7065 for all hospitals.~~

~~3. When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.~~

~~(c)1. Each hospital's case mix and initial budget neutrality adjusted cost per dis-charge shall be multiplied by a hospital-specific outlier payment factor.~~

~~2. A hospital-specific outlier payment factor shall be the result of the following formu-la: ((expected DRG non-outlier payments) -~~

~~(expected proposed DRG outlier payments))/(expected DRG non-outlier payments).~~

~~(d)1. A hospital's case mix, initial budget neutrality and outlier payment adjusted cost~~

per discharge shall be multiplied by a secondary budget neutrality factor.

2. The secondary budget neutrality factor for a hospital shall be 1.0562.

3. When rates are rebased, the secondary budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.

(12)(a) Except as provided in paragraph (b) of this subsection, the department shall make a high volume per diem payment, to an in-state acute care hospital with high Medicaid volume for base year covered Medicaid days referenced in subsection (8) of this section.

(b) High volume per diem criteria shall be based on the number of Kentucky Medicaid days or the hospital's Kentucky Medicaid utilization percentage.

(c)1. A high volume per diem payment shall be made in the form of a per diem add-on amount in addition to the DRG base payment rate encompassing the DRG average length-of-stay days per discharge.

2. The payment shall be equal to the applicable high volume per diem add-on amount multiplied by the DRG average length-of-stay associated with the claim's DRG classification.

(d)1. The department shall determine a per diem payment associated with Medicaid days-based criteria separately from a per diem payment associated with Medicaid utilization-based criteria.

2. If a hospital qualifies for a high volume per diem payment under both the Medicaid days-based criteria and the Medicaid utilization-based criteria, the department shall pay

~~the higher of the two add-on per diem amounts.~~

~~(e) The department shall pay the indicated high volume per diem payment if either the base year covered Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient day's utilization percent meet the criteria established in Table 2 below:~~

~~Table 2. High Volume Adjustment Eligibility Criteria~~			
~~Kentucky Medicaid Inpatient Days~~		~~Kentucky Medicaid Inpatient Days Utilization~~	
~~Days Range~~	~~Per Diem Payment~~	~~Medicaid Utilization Range~~	~~Per Diem Payment~~
~~0 - 3,499 days~~	~~$0 per day~~	~~0.0% - 13.2%~~	~~$0.00 per day~~
~~3,500 - 4,499 days~~	~~$22.50 per day~~	~~13.3% - 16.1%~~	~~$22.50 per day~~
~~4,500 - 5,999 days~~	~~$45.00 per day~~	~~16.2% - 21.6%~~	~~$45.00 per day~~
~~6,000 - 7,399 days~~	~~$80.00 per day~~	~~21.7% - 27.2%~~	~~$81.00 per day~~
~~7,400 - 10,999 days~~	~~$118.15 per day~~	~~27.3% - 100.00%~~	~~$92.75 per day~~
~~11,000 - 19,999 days~~	~~$163.49 per day~~		
~~20,000 and above days~~	~~$325.00 per day~~		

~~(f) The department shall use base year claims data referenced in subsection (8) of this section to determine if a hospital qualifies for a high volume per diem add-on payment.~~

~~(g) The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.~~

~~(h)1. The department shall not make a high volume per diem payment for a level I neonatal care, level II neonatal center, or level III neonatal center claim.~~

~~2. A level I neonatal care, level II neonatal center, or level III neonatal center claim shall be included in a hospital's high volume adjustment eligibility criteria calculation established in paragraph (e), Table 2, of this subsection.~~

~~(13)(a)~~] The department shall make a[~~an additional~~] cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each APR-DRG[~~diagnostic category~~].

(b) A cost outlier shall be subject to QIO review and approval.

(c) A discharge shall qualify for a[~~an additional~~] cost outlier payment if its estimated cost exceeds the APR-DRG's outlier threshold.

(d)1. The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

2.[~~A~~] Medicare operating and[~~or~~] capital-related cost-to-charge ratios[~~ratio~~] shall be extracted from the CMS IPPS Pricer Program with an effective date in the Medicare system as of October 1 of the year prior to the beginning of the universal rate year.

(e)1. The department shall calculate an outlier threshold as the sum of a hospital's APR-DRG base payment or transfer payment and the fixed loss cost threshold.

2. The fixed loss cost threshold shall equal $29,000.

(f) A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

(g) An outlier threshold and cost outlier payment shall be calculated before applying a corridor adjustment.

(12)(a)[~~(14)~~] The department shall calculate APR-DRG[~~a Kentucky Medicaid-specific DRG~~] relative weights when the department[~~weight by~~]:

1. Calculates the statewide average APR-DRG base rate by:

a.[~~(a)~~] Selecting the 3M APR-DRG national weights associated with the APR-DRG grouper version used for payment purposes; and

b. Dividing the 3M APR-DRG national weights for all APR-DRGs by a single case mix scaling factor in a manner that results in the statewide average case mix equaling 1.0 using trimmed base year claims data; or

2. Updating the APR-DRG grouper version, without rebasing statewide APR-DRG base rates, by:

a. Selecting the 3M APR-DRG national weights associated with the APR-DRG grouper version used for payment purposes; and

b. Dividing the 3M APR-DRG national weights for all APR-DRGs by a single factor in a manner that results in the statewide average case mix equaling the prior fiscal year's statewide average case mix.

(b)1. The department shall apply a coding and documentation improvement adjust-

ment to the APR-DRG relative weights.

2. To determine the adjustment referenced in subparagraph 1 of this paragraph, the department shall calculate a statewide average case mix index and a targeted statewide average case mix index.

3. To determine the initial statewide average case mix index, the department shall:

a. Assign APR-DRG classifications, using APR-DRG grouper version 30, to Medicaid fee-for-service DRG claims which covered the period of January 1, 2013 through December 31, 2013; and

b. Use the APR-DRG relative weights effective April 1, 2014.

4. The initial statewide average case mix index referenced in subparagraph 3 of this paragraph shall be the initial targeted statewide average case mix index.

5. To calculate the statewide average case mix index to be effective:

a.(i) July 1, 2015, the department shall use the actual paid DRG claims or actual APR-DRG claims for the prior twelve (12) month-period that ended December 31; or

(ii) For claims paid based on the DRG methodology, rather than the APR-DRG methodology, the department shall assign APR-DRG classifications using APR-DRG grouper version 30; and

b. Beginning July 1, 2016 and for each subsequent July 1, the department shall use the actual paid APR-DRG claims for the previous twelve (12) month period that ended December 31.

6. To calculate the targeted statewide average case mix index to be effective:

a. July 1, 2015, the department shall trend the initial targeted statewide average case mix index referenced in subparagraph 4 of this paragraph by 1.5 percent; and

b. Each July 1, beginning July 1, 2016, the department shall trend the prior July 1 targeted statewide average case mix index by 1.5 percent.

7.a. The department shall not apply a coding and documentation improvement adjustment to the APR-DRG relative weights for any year in which the percentage difference between the actual statewide average case mix index and the targeted statewide average case mix index is less than or equal to plus or minus two (2) percent.

b. If the percentage difference between the actual statewide average case mix index and the targeted statewide average case mix is greater than plus or minus two (2) percent, the department shall proportionally adjust the APR-DRG relative weights so that the actual statewide average case mix index is equal to the targeted statewide average case mix index.

(13)[~~Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this section, with the hospital-specific cost per discharge calculated using state fiscal year 2006 inpatient Medicaid paid claims data;~~

~~(b) Reassigning the DRG classification for the base year claims based on the Medicare DRG in effect in the Medicare inpatient prospective payment system at the time of rebasing. The department shall assign to the base year claims data the Medicare grouper version 24 DRG classifications which were effective in the Medicare inpatient prospective payment system as of October 1, 2006;~~

~~(c) Removing the following claims from the calculation:~~

~~1. Claims data for a discharge reimbursed on a per diem basis including:~~

~~a. A psychiatric claim, defined as follows:~~

~~(i) An acute care hospital claim with a psychiatric DRG;~~

~~(ii) A psychiatric distinct part unit claim; or~~

~~(iii) A psychiatric hospital claim;~~

~~b. A rehabilitation claim, defined as follows:~~

~~(i) An acute care hospital claim with rehabilitation DRG;~~

~~(ii) A rehabilitation distinct part unit claim; or~~

~~(iii) A rehabilitation hospital claim;~~

~~c. A critical access hospital claim; and~~

~~d. A long term acute care hospital claim;~~

~~2. A transplant service claim as specified in subsection (21) of this section;~~

~~3. A claim for a patient discharged from an out-of-state hospital; and~~

~~4. A claim with total charges equal to zero;~~

~~(d) Calculating a relative weight value for a low volume DRG by:~~

~~1.a. Arraying a DRG with less than twenty-five (25) cases in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system at the same time as the Medicare DRG grouper version, published in the Federal Register, relied upon for Kentucky DRG classifications; and~~

~~b. Using the Medicare DRG relative weight which was effective in the Medicare inpatient prospective payment system as of October 1, 2006;~~

~~2. Grouping a low volume DRG, based on the Medicare DRG relative weight sort, into one (1) of five (5) categories resulting in each category having approximately the same number of Medicaid cases;~~

~~3. Calculating a DRG relative weight for each category; and~~

~~4. Assigning the relative weight calculated for a category to each DRG included in~~

~~the category;~~

~~(e)1. Standardizing the labor portion of the cost of a claim for differences in wage and the full cost of a claim for differences in indirect medical education costs across hospitals based on base year Medicare rate components;~~

~~a. Base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and~~

~~b. Base year Medicare rate components used in the Kentucky inpatient prospective payment system shall include:~~

~~(i) Labor-related percentage and non-labor-related percentage;~~

~~(ii) Operating and capital cost-to-charge ratios;~~

~~(iii) Operating indirect medical education costs; or~~

~~(iv) Wage indices;~~

~~2. Standardizing costs using the following formula: standard cost = {((labor related percentage X costs)/Medicare wage index) + (nonlabor related percentage X costs)}/(1 + Medicare operating indirect medical education factor), with:~~

~~a. The labor related percentage equal to sixty-two (62) percent; and~~

~~b. The nonlabor related percentage equal to thirty-eight (38) percent;~~

~~(f) Removing statistical outliers by deleting any case that is:~~

~~1. Above or below three (3) standard deviations from the mean cost per discharge; and~~

~~2. Above or below three (3) standard deviations from the mean cost per day;~~

~~(g) Computing an average standardized cost for all DRGs in aggregate and for each~~

~~DRG, excluding statistical outliers;~~

~~(h) Computing DRG relative weights:~~

~~1. For a DRG with twenty-five (25) claims or more by dividing the average cost per discharge for each DRG by the statewide average cost per discharge; and~~

~~2. For a DRG with less than twenty-five (25) claims by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge;~~

~~(i) Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG based on the base year claims data used to calculate DRG relative weights;~~

~~(j) Employing enhanced neonatal care relative weights;~~

~~(k) Applying an adjustment factor to relative weights not referenced in paragraph (j) of this subsection to offset the level I, II, and III neonatal care relative weight increase resulting from the use of enhanced neonatal care relative weights; and~~

~~(l) Excluding high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal care relative weight calculations.~~

~~(15)~~] The department shall[~~:~~

~~(a)~~] separately reimburse for a mother's stay and a newborn's stay based on the diagnostic category assigned to the mother's stay and to the newborn's stay.

(14)[~~; and~~

~~(b) Establish a unique set of diagnostic categories and relative weights for an in-state acute care hospital identified by the department as providing level I neonatal care, level II neonatal center care, or level III neonatal center care as follows:~~

~~1. The department shall exclude high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal center relative weight calculations;~~

~~2. The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:~~

~~a. DRG 675-680 for an in-state acute care hospital with a level II neonatal center; or~~

~~b. DRG 685-690 for an in-state acute care hospital with a level III neonatal center;~~

~~3. The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and~~

~~4.a. The department shall compute a separate relative weight for a level II, or III neonatal intensity care unit (NICU) neonatal DRG;~~

~~b. The department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights for DRGs 675-680; and~~

~~c. The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.~~

~~(16) The department shall:~~

~~(a) Expend in aggregate by category (level I neonatal care, level II or III neonatal center care) and not by individual facilities:~~

~~1. A total expenditure for level I neonatal care projected to equal 100 percent of Medicaid allowable cost for the universal rate year;~~

~~2. A total expenditure for level II neonatal center care projected to equal 100 percent of Medicaid allowable cost for the universal rate year; or~~

~~3. A total expenditure for Level III neonatal center care projected to equal 100 percent of Medicaid allowable cost for the universal rate year;~~

~~(b) Adjust neonatal care DRG relative weights to result in:~~

~~1. Total expenditures for level I neonatal care projected to equal 100 percent of Medicaid allowable cost for the universal rate year;~~

~~2. Total expenditures for level II neonatal center care projected to equal 100 percent of Medicaid allowable cost for the universal rate year; or~~

~~3. Total expenditures for level III neonatal center care projected to equal 100 percent of Medicaid allowable cost for the universal rate year; and~~

~~(c) Not cost settle reimbursement referenced in this subsection.~~

~~(17) The department shall reimburse an individual:~~

~~(a) Hospital which does not operate a level II or III neonatal center, for level I neonatal care at the statewide average Medicaid allowable cost per each level I DRG;~~

~~(b) Level II neonatal center for level II neonatal care at the average Medicaid allowable cost per DRG of all level II neonatal centers; or~~

~~(c) Level III neonatal center for level III neonatal care at the average Medicaid allowable cost per DRG of all level III neonatal centers.~~

~~(18)~~] If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

(a) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus

one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

1. The department shall calculate an average daily rate by dividing the APR-DRG base payment, excluding any outlier payments and corridor adjustment factor, by the APR-DRG average[~~statewide Medicaid geometric mean~~] length-of-stay[~~for a patient's DRG classification~~].

2. [~~If a hospital qualifies for a high volume per diem add-on payment in accordance with subsection (2) of this section, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.~~

~~3.~~] Total reimbursement to the transferring hospital shall be the sum of the transfer payment amount and, if applicable, a[~~high volume per diem add-on amount and a~~] cost outlier payment amount, multiplied by the provider-specific corridor adjustment factor.

(b) For a hospital receiving a transferred patient, the department shall reimburse the total hospital-specific per discharge payment referenced in Section 2(2) of this administrative regulation.

(15) The department shall calculate an APR-DRG average length of stay by:

(a) Using the 3M national APR-DRG arithmetic mean lengths of stay associated with the APR-DRG grouper version used for payment purposes; and

(b) Multiplying the 3M national APR-DRG arithmetic mean lengths of stay for all APR-DRGs by a single day's adjustment factor in a manner that results in the sum of APR-DRG arithmetic mean lengths equaling the covered days in the trimmed base year claims data.

(16)(a)[~~DRG base payment, and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.~~

~~(19)~~] The department shall pay to the transferring hospital for[~~treat~~] a transfer from an acute care hospital to a qualifying postacute care facility the transfer payment amount referenced in subsection (14) of this section[~~for selected DRGs in accordance with paragraph (b) of this subsection as a postacute care transfer~~].

(b)[~~(a)~~] The following shall qualify as a postacute care setting:

1. A psychiatric, rehabilitation, children's, long-term, or cancer hospital;

2. A skilled nursing facility; or

3. A home health agency.

(17)[~~(b) A DRG eligible for a postacute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(C)(i).~~

~~(c) The department shall pay each transferring hospital an average daily rate for each day of stay.~~

~~1. A payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.~~

~~2. A DRG identified by CMS as being eligible for special payment shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay, up to the full DRG base payment.~~

~~3. A DRG that is referenced in paragraph (b) of this subsection and not referenced in subparagraph 2 of this paragraph shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.~~

~~(d) The per diem amount shall be the base DRG payment allowed divided by the statewide Medicaid geometric mean length of stay for a patient's DRG classification.~~

~~(20)~~] The department shall reimburse for an intrahospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit:

(a) The full APR-DRG base payment allowed; and

(b) The facility-specific distinct part unit per diem rate, in accordance with 907 KAR 10:815[~~1:815~~], for each day the patient remains in the distinct part unit.

(18)[~~(21)(a)~~] The department shall reimburse for an organ[~~a kidney, cornea, pancreas, or kidney and pancreas~~] transplant on a prospective per discharge method according to the recipient's APR-[~~patient's~~] DRG classification.

[~~(b) A transplant not referenced in paragraph (a) of this subsection shall be reimbursed in accordance with 907 KAR 1:350.~~

~~(22) The department shall adjust the non-neonatal care DRGs to result in the aggregate universal rate year reimbursement for all services (non-neonatal and neonatal) to equal the aggregate base year reimbursement for all services (non-neonatal and neonatal) inflated by the trending factor.~~]

Section 3. Never Events. (1) For each diagnosis on a claim, a hospital shall specify on the claim whether the diagnosis was present upon the individual's admission to the hospital.

(2) In assigning an APR-[~~a~~]DRG for a claim, the department shall exclude from the APR-DRG consideration any secondary diagnosis code associated with a hospital-acquired condition.

(3) A hospital shall not seek payment for treatment for or related to a never event through:

(a) A recipient;

(b) The Cabinet for Health and Family Services for a child in the custody of the cabinet; or

(c) The Department for Juvenile Justice for a child in the custody of the Department for Juvenile Justice.

(4) A recipient, the Cabinet for Health and Family Services, or the Department for Juvenile Justice shall not be liable for treatment for or related to a never event.

(5) The department's treatment of never events shall not affect the calculation of APR-DRG base rates or relative weights:

(a) Previously implemented by the department; or

(b) As described in Section 2 of this administrative regulation.

Section 4. Preadmission Services for an Inpatient Acute Care Service. A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

(1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and

(2) Exclude a service furnished by a home health agency, a skilled nursing facility or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Section 5. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs. (1) If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to federal regulation or law, the department shall not reimburse for direct gradu-

ate medical education costs.

(2) If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows:

(a) A payment shall be made:

1. Separately from the per discharge[~~and per diem~~] payment methodology[~~methodologies~~]; and

2. On an annual basis; and

(b) The department shall determine an annual payment amount for a hospital as established in this paragraph.[~~follows:~~]

1. The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by each approved hospital's Medicare fiscal intermediary.[~~;~~]

2. The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected.[~~;~~]

3. The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount shall be the estimated total approved direct graduate medical education costs.[~~;~~]

4. The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's Medicare[~~most recently finalized~~] cost report with a reporting period ending during the state fiscal year

for which annual graduate medical education payment calculations are performed[~~on Worksheet D, Part 1~~], to determine an average approved graduate medical education cost per day amount.[~~;~~]

5. The average graduate medical education cost per day amount shall be multiplied by the number of Medicaid fee-for-service[~~total~~] covered days for the hospital, excluding claims reimbursed on a per diem rate methodology, as reported by the Medicaid Management Information System in the state fiscal year for which graduate medical education payment calculations are performed[~~base year claims data~~] to determine the total graduate medical education costs related to the Medicaid Program.[~~; and~~]

6. Medicaid Program graduate medical education costs shall then be multiplied by the statewide average pay-to-cost ratio calculated using base year claims data referenced in Section 2(10) of this administrative regulation[~~budget neutrality factor~~].

Section 6. Aggregate Target Payments[~~Budget Neutrality Factors~~]. (1)(a) When rates are rebased, estimated projected reimbursement in the universal rate year using trimmed base year claims data shall not exceed reported payments[~~for the same services~~] in the trimmed base[~~prior~~] year claims data adjusted by the trending factor.

(b) The trending factor shall be based on the cumulative APR-DRG or DRG base rates that has occurred since the base year period to the universal rate year[~~for inflation based on changes in the Price Index Levels in the CMS IPPS Hospital Input Price Index~~].

(2) The estimated total payments for each facility under the reimbursement methodology in effect during the base year claims data period[~~in the year prior to the universal~~] rate year shall be based on[~~estimated from~~] base year claims data reported payments

adjusted by the trending factor.

(3) The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from trimmed base year claims data.

(4) When rebasing, the single statewide APR-DRG base rate shall be set in a way that results in estimated payments in the universal rate year using trimmed base year claims data not exceeding reported payments in the trimmed base year claims data adjusted by the trending factor[~~If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rate shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total adjusted payments in the year prior to the universal rate year~~].

Section 7. Reimbursement Updating Procedures. (1) For rate years between rebasing periods, the department shall annually, on July 1, update the APR-DRG[~~hospital-specific~~] base rates for inflation based on changes in the [~~Price Index Levels in the~~] CMS IPPS Hospital Input Price Index levels from the midpoint of the previous rate year to the midpoint of the universal rate year.

(2) The department shall annually, on July 1, update the hospital-specific outlier cost-to-charge ratios using the sum of the Medicare operating and capital outlier-related cost-to-charge ratios extracted from the CMS IPPS Pricer Program with an effective date in the Medicare system as of October 1 of the year prior to the beginning of the universal rate year.

(3)(a) The APR-DRG grouper version shall be updated each October 1 in accordance with Section 2(3)(b) of this administrative regulation.

(b) The department shall also update the APR-DRG grouper version using the most current APR-DRG version available at the time the department rebases the APR-DRG base rates.

(c) When updating the APR-DRG grouper version, the department shall calculate new APR-DRG relative weights in accordance with Section 2(12) of this administrative regulation.

(4) Except for an appeal in accordance with Section 20[~~21~~] of this administrative regulation, the department shall make no other adjustment.

(5)[~~(3)~~] The department shall rebase APR-DRG reimbursement rates at least once every four (4) years[~~on July 1, 2012 and every fourth year after that~~].

Section 8. Use of a Universal Rate Year. (1) A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.

(2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

Section 9. Cost Reporting Requirements. (1)(a) An in-state hospital participating in the Medicaid Program shall submit to the department, in accordance with the requirements in this section:

1. A copy of each Medicare cost report it submits to CMS;

2.[~~,~~] An electronic cost report file (ECR);

3.[~~,~~] The Supplemental Medicaid Schedule KMAP-1;

4.[~~and~~] The Supplemental Medicaid Schedule KMAP-4; and

5. The Supplemental Medicaid Schedule KMAP-6[~~as required by this subsection~~].

(b)[~~(a)~~] A document listed in paragraph (a) of this subsection[~~cost report~~] shall be submitted:

1. For the fiscal year used by the hospital; and

2. Within five (5) months after the close of the hospital's fiscal year.

(c)[~~(b)~~] Except as provided in subparagraph 1 or 2 of this paragraph, the department shall not grant a cost report submittal extension.

1. If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or

2. If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.

(2) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

(3) A cost report submitted by a hospital to the department shall be subject to audit and review.

(4) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

Section 10. Unallowable Costs. (1) The following shall not be allowable cost for Medicaid reimbursement:

(a) A cost associated with a political contribution;

(b) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services. A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(c) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity, subject to the limitations of subparagraphs 1 and 2 of this paragraph.

1. A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.

2. If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.

(2) A hospital shall identify an unallowable cost on a Supplemental Medicaid Schedule KMAP-1.

(3) A Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted to the department with an annual cost report.

Section 11.[~~Trending of a Cost Report for DRG Re-basing Purposes. (1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or unaudited, shall be trended to the beginning of the universal rate year to update a hospital's Medicaid cost.~~

~~(2) The department shall trend for inflation based on changes in the Price Index Levels in the CMS IPPS Hospital Input Price Index.~~

~~Section 12. Indexing for Inflation. (1) After an allowable Medicaid cost has been~~

~~trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.~~

~~(2) The department shall trend for inflation based on changes in the Price Index Levels in the CMS IPPS Hospital Input Price Index.~~

~~Section 13.~~] Readmission. (1) An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

(2) Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

Section 12.[~~14.~~] Reimbursement for Out-of-state Hospitals. (1) The department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, for inpatient care:

(a) On a fully-prospective per discharge basis based on the patient's diagnostic category; and

(b) An all-inclusive rate.

(2) The all-inclusive rate referenced in subsection (1)(b) of this section shall:

(a) Equal eighty (80) percent of the in-state APR-DRG[~~facility-specific Medicare~~] base rate referenced in Section 2(5) of this administrative regulation multiplied by the APR-DRG relative weight referenced in Section 2(12) of this administrative regulation, reduced in accordance with paragraph (b) of this subsection[~~:~~

~~1. 0.7065; and~~

~~2. The Kentucky-specific DRG relative weights after the relative weights have been reduced by twenty (20) percent~~];

(b) Exclude:

1. Medicare indirect medical education cost or reimbursement;

2. Policy adjusters[~~High volume per diem add-on reimbursement~~];

3. Corridor adjustments[~~Disproportionate share hospital distributions~~]; and

4. Any adjustment mandated for in-state hospitals pursuant to KRS 205.638; and

(c) Include a cost outlier payment if the associated discharge meets the cost outlier criteria established in Section 2(11)[~~(13)~~] of this administrative regulation.

1. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.

2. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the Medicare statewide average[~~hospital-specific~~] operating and capital[~~capital-related mean~~] cost-to-charge ratios by the discharge-allowed charges.

3. The department shall use the average of the urban and rural Medicare statewide average operating and capital-related cost-to-charge ratios for Kentucky published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.[~~; and~~]

4. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

5. A cost outlier shall be subject to quality improvement organization review and ap-

proval.

(3) The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, an all-inclusive rate equal to the average all-inclusive APR-DRG base rate paid to in-state children's hospitals.

(4) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center:

(a) Using[~~at~~] the hospital-specific Medicare base rate extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided, multiplied by eight-five (85) percent;

(b) For an outlier, using the hospital-specific Medicare operating and capital-related cost-to-charge ratio, extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided[~~, multiplied by eighty-five (85) percent~~]. For example, if care was provided on September 13, 2014[~~2008~~], the cost-to-charge ratio used shall be the cost-to-charge ratio extracted from the CMS IPPS Pricer Program in effect on September 13, 2014[~~2008~~].

(5) An out-of-state provider shall not be eligible to receive[~~high volume per diem add-on payments,~~] indirect medical education reimbursement or disproportionate share hospital payments.

Section 13.[~~(5) The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost~~

~~outlier shall be subject to Quality Improvement Organization review and approval.~~

~~(a) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.~~

~~(b) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.~~

~~(c) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.~~

~~(d) The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.~~

~~Section 15.~~] Supplemental Payments. (1) Payment of a supplemental payment established in this section shall be contingent upon the department's receipt of corresponding federal financial participation.

(2) If federal financial participation is not provided to the department for a supplemental payment, the department shall not make the supplemental payment.

(3) In accordance with subsections (1) and (2) of this section, the department shall:

(a) In addition to a payment based on a rate developed under Section 2 of this administrative regulation, make quarterly supplemental payments to:

1. A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

a. Equal to the sum of the hospital's Medicaid shortfall for Medicaid fee-for-service

recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

b. Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid fee-for-service recipients under the age of eighteen (18);

2. A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount:

a. Equal to the difference between payments made in accordance with Sections 2, 4, and 5 of this administrative regulation and the amount allowable under 42 C.F.R. 447.272, not to exceed the payment limit as specified in 42 C.F.R. 447.271;

b. That is prospectively determined subject to a year-end reconciliation[~~with no end of the year settlement~~]; and

c. Based on the state matching contribution made available for this purpose by a facility that qualifies under this paragraph; and

3. A hospital that qualifies as an urban trauma center hospital in an amount:

a. Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph;

b. Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph;

c. That is prospectively determined with an end of the year settlement; and

d. That is consistent with the requirements of 42 C.F.R. 447.271;

(b) Make quarterly supplemental payments to the Appalachian Regional Hospital system:

1. In an amount that is equal to the lesser of:

a. The difference between what the department pays for inpatient services pursuant to Sections 2, 4, and 5 of this administrative regulation and what Medicare would pay for inpatient services to Medicaid eligible individuals; or

b. $7.5 million per year in aggregate;

2. For a service provided on or after July 1, 2005; and

3. Subject to the availability of coal severance funds, in addition to being subject to the availability of federal financial participation, which supply the state's share to be matched with federal funds; and

(c) Base a quarterly payment to a hospital in the Appalachian Regional Hospital System on its Medicaid claim volume in comparison to the Medicaid claim volume of each hospital within the Appalachian Regional Hospital System[~~; and~~

~~(d) Make a supplemental payment to an in-state high intensity level II neonatal center of $2,870 per paid discharge for a DRG 675 – 680~~].

(4) An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility.

(5) For the purpose of this section, Medicaid patient days shall not include enrollee days[~~for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described in 907 KAR 1:705~~].

(6) A payment made under this section shall not duplicate a payment made via 907 KAR 10:820[~~1:820~~].

(7) A payment made in accordance with this section shall be in compliance with the

limitations established in 42 C.F.R. 447.272.

Section 14.[~~16.~~] Certified Public Expenditures. (1)(a) The department shall reimburse an in-state public government-owned or operated hospital the full cost of a Medicaid fee-for-service[~~an~~] inpatient service via a certified public expenditure (CPE) contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

(b) A payment referenced in paragraph (a) of this subsection shall be limited to the federal match portion of the hospital's uncompensated care cost for inpatient Medicaid fee-for-service recipients.

(2) To determine the amount of costs eligible for a CPE, a hospital's allowed charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

(3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

(4)(a) Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for the period.

(b) If any difference between actual cost and submitted costs remains, the department shall reconcile any difference with the provider.

Section 15.[~~17.~~] Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

(1) The contract shall contain a provision granting the department access:

(a) To the subcontractor's financial information; and

(b) In accordance with 907 KAR 1:672; and

(2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

Section 16.[~~18.~~] New Provider, Change of Ownership, or Merged Facility. (1) The department shall reimburse a new acute care hospital based on the APR-DRG methodology with no corridor adjustment factor.

(2) If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.

[~~(2)(a) Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.~~

~~(b) During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.~~]

(3) If two (2) or more separate entities merge into one (1) organization, the department shall:

(a) Merge the latest available data used for rate setting;

(b) Combine bed utilization statistics, creating a new occupancy ratio;

(c) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

(d) If one (1) of the facilities merging has disproportionate share hospital status and the other does not, retain for the merged facility the status of the facility which reported the highest number of Medicaid days paid[~~Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting~~]; and

(e) Require each provider to submit a cost report for the period:

1. Ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end; and

2. Starting with the day of the merger and ending on the fiscal year end of the merged entity in accordance with Section 9 of this administrative regulation.

(4) In the merger of two (2) APR-DRG facilities, the corridor adjustment factor of the purchasing facility shall apply to the merged facility.

(5) In the merger of a per diem facility and an APR-DRG facility, the merged facility shall receive reimbursement based on the APR-DRG methodology.

Section 17.[~~19.~~] Federal Financial Participation. A provision established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the provision; or

(2) Disapproves the provision.

Section 18.[~~20.~~] Department reimbursement for inpatient hospital care shall not exceed the upper payment limit established in 42 C.F.R. 447.271 or 447.272.

Section 19. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a service or item covered pursuant to 907 KAR 10:012 and this administrative regulation.

Section 20. Matters Subject to an Appeal.[~~21. Appeals. (1)~~] An administrative review shall not be available regarding[~~for the following~~]:

(a)1. The methodologies used in determining the:

a. Statewide APR-DRG base rate;

b. Policy adjusters;

c. Corridor adjustment factors; or

d. Cost outlier;

(b) The[~~A~~] determination of the requirement, or the proportional amount, of an aggregate target payment[~~a budget neutrality~~] adjustment in the prospective payment rate;

(c)[~~or (b)~~] The establishment of:

1. DRGs including APR-DRGs[~~Diagnostic related groups~~];

2. The methodology for the classification of an inpatient discharge within an APR-[~~a~~]DRG; or

3. An appropriate weighting factor which reflects the relative hospital resources used with respect to a discharge within an APR-DRG; or

(d) Any differences noted in the calculations of, or data not matching the actual source documents used to calculate the, APR-DRG relative weights; statewide APR-DRG base rate; policy adjusters; or corridor adjustment factors that would result in either a one (1) percent or less change in the statewide APR-DRG base rate or a one (1) and a half percent change in the statewide pay-to-cost ratio[~~a DRG.~~

~~(2) An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671~~].

Section 21. Appeal Process. (1) An appeal shall comply with the requirements and provisions established in this section of this administrative regulation.

(2)(a) A request for a review of an appealable issue shall be received by the department within sixty (60) calendar days of the date of receipt by the provider of the de-

partment's notice of rates set under this administrative regulation.

(b) The request referenced in paragraph (a) of this subsection shall:

1. Be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002; and

2. Contain the specific issues to be reviewed with all supporting documentation necessary for the departmental review.

(3)(a) The department shall review the material referenced in subsection (2) of this section and notify the provider of the review results within thirty (30) days of its receipt except as established in paragraph (b) of this subsection.

(b) If the provider requests a review of a non-appealable issue under this administrative regulation, the department shall:

1. Not review the request; and

2. Notify the provider that the review is outside of the scope of this section.

(4)(a) A provider may appeal the result of the department’s review, except for a notification that the review is outside the scope of this section, by sending a request for an administrative hearing to the Division for Administrative Hearings (DAH) within thirty (30) days of receipt of the department’s notification of its review decision.

(b) A provider shall not appeal a notification that a review is outside of the scope of this section.

(5)(a) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.

(b) Pursuant to KRS 13B.030, the secretary of the Cabinet for Health and Family

Services delegates to the Cabinet for Health and Family Services, Division for Administrative Hearings (DAH) the authority to conduct administrative hearings under this administrative regulation.

(c) A notice of the administrative hearing shall comply with KRS 13B.050.

(d) The administrative hearing shall be held in Frankfort, Kentucky no later than ninety (90) calendar days from the date the request for the administrative hearing is received by the DAH.

(e) The administrative hearing date may be extended beyond the ninety (90) calendar days by:

1. A mutual agreement by the provider and the department; or

2. A continuance granted by the hearing officer.

(f)1. If the prehearing conference is requested, it shall be held at least thirty (30) calendar days in advance of the hearing date.

2. Conduct of the prehearing conference shall comply with KRS 13B.070.

(g) If a provider does not appear at the hearing on the scheduled date and the hearing has not been previously rescheduled, the hearing officer may find the provider in default pursuant to KRS 13B.050(3)(h).

(h) A hearing request shall be withdrawn only under the following circumstances:

1. The hearing officer receives a written statement from a provider stating that the request is withdrawn; or

2. A provider makes a statement on the record at the hearing that the provider is withdrawing the request for the hearing.

(i) Documentary evidence to be used at the hearing shall be made available in ac-

cordance with KRS 13B.090.

(j) The hearing officer shall:

1. Preside over the hearing; and

2. Conduct the hearing in accordance with KRS 13B.080 and 13B.090.

(k) The provider shall have the burden of proof concerning the appealable issues under this administrative regulation.

(l)1. The hearing officer shall issue a recommended order in accordance with KRS 13B.110.

2. An extension of time for completing the recommended order shall comply with the requirements of KRS 13B.110(2) and (3).

(m)1. A final order shall be entered in accordance with KRS 13B.120.

2. The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.

3. In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140 and 13B.150.

Section 23.[~~22.~~] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Supplemental Medicaid Schedule KMAP-1"; 2013[~~January 2007~~] edition;

(b) "Supplemental Medicaid Schedule KMAP-4", 2013[~~January 2007~~] edition; [~~and~~]

(c) "Supplemental Medicaid Schedule KMAP-6", 2013 edition; and

(d) "CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101", June 12, 2009 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copy-

right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 10:825

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

907 KAR 10:825
PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on January 22, 2014 at 9:00 a.m. in the Health Services Auditorium, Suite B, of the Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by January 15, 2014 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until January 31, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 10:825
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Jill Hunter (502) 564-5707 or Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) reimbursement policies for care provided by inpatient acute care hospitals (reimbursed via a diagnosis-related group methodology) to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse in the same manner as DMS for services provided by an inpatient acute care hospital.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Kentucky Medicaid program reimbursement policies for hospitals reimbursed via a diagnosis-related group methodology.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Kentucky Medicaid program reimbursement policies for hospitals reimbursed via a diagnosis-related group methodology.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing the Kentucky Medicaid program reimbursement policies for hospitals reimbursed via a diagnosis-related group methodology.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment replaces the current diagnosis related group (DRG)-based reimbursement methodology (which is based on a Medicare DRG grouper) with a methodology based on a system owned by 3M known as the "3M™ All Patient Refined DRG (APR DRG) Classification System." The 3M APR-DRG system is currently used by at least nine (9) states' Medicaid programs including border states Tennessee and West Virginia.

The 3M DRG system more accurately captures and identifies the resources involved in caring for inpatient hospital patients due to enhanced identification of the patients' conditions. For example, this system includes four (4) severity-of-illness levels and four (4) risk-of-mortality levels within each diagnosis related group (DRG). 3M's software classifies patients using clinical logic that assesses factors such as age, comorbidities, primary diagnosis, and necessary procedures. Additionally, it captures information on the full array of patients (regardless of

payor source, i.e. Medicare, Medicaid, private insurance, no insurance) in an inpatient acute care hospital. The 3M system also contains more neonatal DRGs than the version (Medicare grouper) currently used by DMS. The amendment also establishes that DMS will reimburse for organ transplants through the DRG methodology (this administrative regulation) – currently DMS pays for organ transplants via another administrative regulation (907 KAR 1:350) at eight (80) percent of the hospital's usual and customary charge not to exceed $75,000; establishes that DMS's reimbursement for out-of-state hospitals (other than Vanderbilt Medical Center and a children's hospital located in a Metropolitan Statistical Area whose boundaries overlap Kentucky) will be eighty (80) percent of the in-state APR-DRG base rate multiplied by APR-DRG relatives weights [previously DMS paid such a hospital the hospital's Medicare base rate multiplied by 0.7065 and the Kentucky-specific DRG relative weights after the relatives weights had been reduced by twenty (20) percent]; revises the matters subject to appeal, based on the new methodology; and states the appeals process for appealing hospital reimbursement. Previously, the administrative regulation did not state the appeals process.

(b) The necessity of the amendment to this administrative regulation: Adopting the new DRG reimbursement model is necessary to enhance DMS's reimbursement by using a system that more accurately captures and identifies (for reimbursement purposes) the resources involved in caring for inpatient acute care hospital patients as well as adopting a model that is compatible with the new international coding system (for health care conditions) that is mandated to become effective October 1, 2014. The current coding system is the International Classification of Diseases -9 or ICD-9. The updated system (which is ICD-10) becomes effective October 1, 2014. The ICD-10 system contains much more detail than the current system and DMS's current DRG reimbursement model is incompatible with the ICD-10 system. The new methodology established in this administrative regulation (the APR-DRG model) is compatible with ICD-10 and would enable DMS to pay for acute care hospital claims. The existing DRG model would not enable DMS to pay for acute care hospital claims.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by enhancing DMS's reimbursement by using a reimbursement model that more accurately captures and identifies (for reimbursement purposes) the resources involved in caring for inpatient acute care hospital patients as well as adopting a reimbursement model that is compatible with the upcoming coding classification system change from ICD-9 to ICD-10.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by enhancing DMS's reimbursement by using a reimbursement model that more accurately captures and identifies (for reimbursement purposes) the resources involved in caring for inpatient acute care hospital patients as well as adopting a reimbursement model that is compatible with the upcoming coding classification system change from ICD-9 to ICD-10.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The amendment applies to all inpatient acute care hospitals reimbursed by a diagnosis related grouper methodology. Currently, there are approximately sixty-five (65) acute care hospitals participating in the Kentucky Medicaid program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No compliance action is mandated.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This amendment imposes no cost on the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Inpatient acute care hospitals will be reimbursed via a methodology designed to more accurately capture and reflect their costs.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The amendment does not result in additional costs to the Department for Medicaid Services for the first year.

(b) On a continuing basis: The amendment does not result in additional costs to the Department for Medicaid Services for subsequent years.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding will be necessary to implement the amendment to this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is not applied as the amendment applies to all regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 10:825
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30) and 42 C.F.R.447.205.

2. State compliance standards. KRS 205.520(3) states, “to qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:
“. . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

   42 C.F.R. 447.205 mandates that the state provide public notice of reimbursement changes.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter than the federal standard.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 10:825
Agency Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS anticipates no revenue above the current revenue level being generated for the first year for state or local government due to the amendment to this administrative regulation.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue above the current revenue level being generated in subsequent years for state or local government due to the amendment to this administrative regulation.
(c) How much will it cost to administer this program for the first year? The amendment does not result in additional costs to the Department for Medicaid Services for the first year.
(d) How much will it cost to administer this program for subsequent years? The amendment does not result in additional costs to the Department for Medicaid Services for subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-): ____
Expenditures (+/-): ____
Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 10:825, Diagnosis-related group (DRG) inpatient hospital reimbursement

Summary of Material Incorporated by Reference

(1) The “Supplemental Medicaid Schedule KMAP-1”, 2013 edition is a form currently incorporated by reference that is being revised. The 2013 edition replaces the January 2007 edition. This one (1) page form is used by participating hospitals to report various hospital costs. Revisions include changing the instructions in column 2 to refer to the current line numbers on the Medicare Cost Report Worksheet B.

(2) The “Supplemental Medicaid Schedule KMAP-4”, 2013 edition is also a form currently incorporated by reference that is being revised. The 2013 edition replaces the January 2007 edition. This one (1) page form is a questionnaire used by participating hospitals to report information regarding disproportionate share hospital care. The form was revised to state the edition date as being 2013 rather than January 2007.

(3) “Supplemental Medicaid Schedule KMAP-6”, 2013 edition is a new one (1) page form that is also used by participating hospitals to report costs related to labor-delivery rooms and nurseries.

(4) The “CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101”; June 12, 2009 edition is an eleven (11)-page document establishing procedures, services, or hospitalizations known as never events which are not reimbursable by the Centers for Medicare and Medicaid Services (CMS). The Department for Medicaid Services (DMS) is mirroring the CMS policy regarding these procedures, services, or hospitalizations.

A total of fourteen (14) pages are incorporated by reference.